

Centers for Medicare & Medicaid Services, HHS

§ 425.20

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AUTHORITY: Secs. 1102, 1106, 1871, and 1899 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

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Subpart A—General Provisions

§ 425.10 Basis and scope.

(a) *Basis.* This part implements section 1899 of the Act by establishing a shared savings program that promotes accountability for a patient population, coordinates items and services under Medicare parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient services. The regulations under this part must not be construed to affect the payment, coverage, program integrity, and other requirements that apply to providers and suppliers under FFS Medicare.

(b) *Scope.* This part sets forth the following:

(1) The eligibility requirements for an ACO to participate in the Medicare Shared Savings Program (Shared Savings Program).

(2) Application procedures and provisions of the participation agreement.

(3) Program requirements and beneficiary protections.

(4) The method for assigning Medicare fee-for-service beneficiaries to ACOs.

(5) Quality performance standards, reporting requirements, and data sharing.

(6) Payment criteria and methodologies (one-sided model and two-sided model).

(7) Compliance monitoring and sanctions for noncompliance.

(8) Reconsideration review process.

§ 425.20 Definitions.

As used in this part, unless otherwise indicated—

Accountable care organization (ACO) means a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a Taxpayer Identification Number (TIN), and is formed by one or more ACO participants(s) that is(are) defined at § 425.102(a) and may also include any other ACO participants described at § 425.102(b).

ACO participant means an individual or group of ACO provider(s)/supplier(s), that is identified by a Medicare-enrolled TIN, that alone or together with one or more other ACO participants comprise(s) an ACO, and that is included on the list of ACO participants that is required under § 425.204(c)(5).

ACO professional means an ACO provider/supplier who is either of the following:

(1) A physician legally authorized to practice medicine and surgery by the State in which he performs such function or action.

(2) A practitioner who is one of the following:

(i) A physician assistant (as defined at § 410.74(a)(2) of this chapter).

(ii) A nurse practitioner (as defined at § 410.75(b) of this chapter).

(iii) A clinical nurse specialist (as defined at § 410.76(b) of this chapter).

ACO provider/supplier means an individual or entity that—

(1) Is a provider (as defined at § 400.202 of this chapter) or a supplier (as defined at § 400.202 of this chapter);

(2) Is enrolled in Medicare;

(3) Bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations; and

(4) Is included on the list of ACO providers/suppliers that is required under § 425.204(c)(5).

Agreement period means the term of the participation agreement which begins at the start of the first performance year and concludes at the end of the final performance year.

Antitrust Agency means the Department of Justice or Federal Trade Commission.

Assignment means the operational process by which CMS determines whether a beneficiary has chosen to receive a sufficient level of the requisite primary care services from a physician who is an ACO provider/supplier so that the ACO may be appropriately designated as exercising basic responsibility for that beneficiary's care.

At-risk beneficiary means, but is not limited to, a beneficiary who—

(1) Has a high risk score on the CMS–HCC risk adjustment model;

(2) Is considered high cost due to having two or more hospitalizations or emergency room visits each year;

(3) Is dually eligible for Medicare and Medicaid;

(4) Has a high utilization pattern;

(5) Has one or more chronic conditions.

(6) Has had a recent diagnosis that is expected to result in increased cost.

(7) Is entitled to Medicaid because of disability; or

(8) Is diagnosed with a mental health or substance abuse disorder.

Continuously assigned beneficiary means a beneficiary assigned to the ACO in the current performance year who was either assigned to or received a primary care service from any of the ACO's participant during the most recent prior calendar year.

Covered professional services has the same meaning given these terms under section 1848(k)(3)(A) of the Act.

Critical access hospital (CAH) has the same meaning given this term under § 400.202 of this chapter.

Eligible professional has the meanings given this term under section 1848(k)(3)(B) of the Act.

Federally qualified health center (FQHC) has the same meaning given to this term under § 405.2401(b) of this chapter.

Hospital means a hospital subject to the prospective payment system specified in § 412.1(a)(1) of this chapter.

Marketing materials and activities include, but are not limited to, general audience materials such as brochures, advertisements, outreach events, letters to beneficiaries, Web pages, data sharing opt out letters, mailings, social media, or other activities conducted by or on behalf of the ACO, or by ACO participants, or ACO providers/suppliers participating in the ACO, when used to educate, solicit, notify, or contact Medicare beneficiaries or providers and suppliers regarding the Shared Savings Program. The following beneficiary communications are not marketing materials and activities: Certain informational materials customized or limited to a subset of beneficiaries; materials that do not include information about the ACO, its ACO participants, or its ACO providers/suppliers; materials that cover beneficiary-specific billing and claims issues or other specific individual health related issues; educational information on specific medical conditions (for example, flu shot reminders), written referrals for health care items and services, and materials or activities that do not constitute “marketing” under 45 CFR 164.501 and 164.508(a)(3)(i).

Medicare fee-for-service beneficiary means an individual who is—

(1) Enrolled in the original Medicare fee-for-service program under both parts A and B; and

(2) Not enrolled in any of the following:

(i) A MA plan under part C.

(ii) An eligible organization under section 1876 of the Act.

(iii) A PACE program under section 1894 of the Act.

Medicare Shared Savings Program (Shared Savings Program) means the program, established under section 1899 of the Act and implemented in this part.

Newly assigned beneficiary means a beneficiary that is assigned in the current performance year who was neither assigned to nor receives a primary care service from any of the ACO's participants during the most recent prior calendar year.

One-sided model means a model under which the ACO may share savings with the Medicare program, if it meets the requirements for doing so, but is not liable for sharing any losses incurred under subpart G of this part.

Performance year means the 12-month period beginning on January 1 of each year during the agreement period, unless otherwise noted in the ACO's agreement. For an ACO with a start date of April 1, 2012 or July 1, 2012, the ACO's first performance year is defined as 21 months and 18 months, respectively.

Physician means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

Physician Quality Reporting System (PQRS) means the quality reporting system established under section 1848(k) of the Act.

Primary care physician means a physician who has a primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine, or, for services furnished in an FQHC or RHC, a physician included in an attestation by the ACO as provided under § 425.404.

Primary care services mean the set of services identified by the following HCPCS codes:

- (1) 99201 through 99215.
- (2) 99304 through 99340, and 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for the annual wellness visits);
- (3) Revenue center codes 0521, 0522, 0524, 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.

Quality measures means the measures defined by the Secretary, under section 1899 of the Act, to assess the quality of care furnished by an ACO, such as measures of clinical processes and outcomes, patient and, where practicable, caregiver experience of care and utilization.

Reporting period, for purposes of subpart F of this part, means the calendar year from January 1 to December 31.

Rural health center (RHC) has the same meaning given to this term under § 405.2401(b).

Shared losses means a portion of the ACO's performance year Medicare fee-for-service Parts A and B expenditures, above the applicable benchmark, it must repay to CMS. An ACO's eligibility for shared losses will be determined for each performance year. For an ACO requesting interim payment, shared losses may result from the interim payment calculation.

Shared savings means a portion of the ACO's performance year Medicare fee-for-service Parts A and B expenditures, below the applicable benchmark, it is eligible to receive payment for from CMS. An ACO's eligibility for shared savings will be determined for each performance year. For an ACO requesting interim payment, shared savings may result from the interim payment system calculation.

Taxpayer Identification Number (TIN) means a Federal taxpayer identification number or employer identification number as defined by the IRS in 26 CFR 301.6109-1.

Two-sided model means a model under which the ACO may share savings with the Medicare program, if it meets the requirements for doing so, and is also liable for sharing any losses incurred under subpart G of this part.

Subpart B—Shared Savings Program Eligibility Requirements

§ 425.100 General.

(a) Under the Shared Savings Program, ACO participants may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO that meets the criteria specified in this part. The ACO must become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

(b) ACOs that meet or exceed a minimum savings rate established under § 425.604 or § 425.606, meet the minimum quality performance standards established under § 425.500, and otherwise